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The Role of Research Evidence for Linking RH/HIV/AIDS Programs*

By

Bettina Maas[1]

The ICPD PoA with its emphasis on improving sexual and promoting gender equality marked a major paradigm shift toward integrated client-centered reproductive health policies and programs. This paradigm shift has represented, in many settings, a diverging trend from the vertically structured family planning programs to more focus on promoting broadly-defined sexual and reproductive health for all through horizontally integrated primary health care and family planning services (1).

While broadening the range of care to include "a constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving health problems," the definition also makes it clear that sexual and reproductive health (SRH) involves more than health care, and its objectives can not be achieved by the health sector alone. As recapitulated by the 2005 report of the UN Millennium Project, SRH affects, and is affected by, other MDGs, including poverty reduction and gender equality and empowerment of women (2). Improvement in SRH outcomes, whether reduction in unwanted pregnancies, reduced maternal mortality or reduced sexually transmitted diseases, including HIV/AIDS, depends on contextual factors, such as cultural norms, political reinforcement, the accessibility of and quality of services and the modality of packaging and managing the services.

Though there is increased recognition of the interaction between sexual and reproductive health and HIV/AIDS and improved SRH programming practices have been recorded in the years since the 1994 ICPD and the 2000 Millennium Summit, there still remains gaps in identifying the effective way of packaging and delivering various types of care at different levels of the health system. SRH services often constitute of significant part of such packages. In general, poor and scarce-resource countries may be delivering only a few of the services in the desired package or fragmenting a typically and substantively interlinked constellation of services. In particular, several national programming experiences have encountered partitioning such constellations into individual components of the whole.

[1] Chief Porgramme Support and Regional Desks Branch, Programme Division, UNFPA

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Rationale for Linking HIV/AIDS and SRH.

Allegedly, vertical approaches to HIV/AIDS services threaten to fragment the SRH care agenda; to ignore its common biological and behavioral foundations and health care requirements; and draw clinically needed resources away from basic sexual and reproductive health-care services rather than strengthening each country's capacity to provide the basic integrated services (3). To a great extent, the fast spread of HIV/AIDS pandemic and its devastating impacts on human development, particularly in the developing world, has stirred the disintegrated programming approach to linking HIV/AIDS and SRH. Because of the steady increase in global figures on the spread of HIV/AIDS endemic and the changing characteristics of its victims (e.g. disproportionate increase among women, adolescents and young adults), reducing the HIV incidence has become one of the Millennium Development Goals more strongly pursued.

As reported by Ian Askew and Marge Berer (4) "approximately 80% of HIV cases are transmitted sexually and a further 10% perinatally or during breastfeeding. Hence, the health sector has looked to sexual and reproductive heath programs for leadership and guidance in providing information and counseling to prevent these forms of transmission, and more recently to some aspects of treatment".

There are a host of reasons to link SRH and HIV/AIDS programs. Citing a condensed, however well thought-out, synopsis by Lule (2004), "both programs address human sexuality, serve similar target groups, promote safe responsible sexual behavior, treat sexually transmitted infections, rely on prevention, and promote and distribute condoms within and outside clinics and health services" (5).

Other synergies include a number of pertinent programmatic interconnections. First, both programs require and use similar medical and health skills and facilities and rely on community participation to address sensitive sexuality issues and socio-cultural determinants of behavior change. Second, both have common objectives and desire common outcomes, including improving maternal health (MDG5) and reducing child mortality (MDG4). Third, both are interested in addressing the vulnerability and high risk behaviors of young people that fuel the HIV epidemic in this age group and contribute to early childbearing and high maternal and infant mortality. Fourth, both focus and rely on behavior change ad employ similar behavior change communication channels.

However, these positive synergies and promising returns stemming from the integrated HIV/AIDS/SRH programs are always challenged by a set of limitations and constraints. Proponents of vertical programming of HIV/AIDS tend to claim that this endemic typically expands beyond the boundaries of SRH (i.e. MCH/FP) and include many groups that are at high risk of becoming infected (youth, sex workers, etc.) do not use traditional services that are geared to serve mothers and children. Also, advocates of HIV/AIDS claim to fight hard to achieve recognition of the seriousness of the epidemic and for funding to combat it, occasionally believing that any connections with the rights-based SRH/FP programs may antagonize the traditional opponents of these programs and, thus, instigate them to reduce or curtail the pledged financial and technical support.

The Framework for Priority Linkages developed by WHO UNFPA, UNAIDS and IPPF clearly indentifies the various levels of interaction and proposes key actions for public health benefits. It also recognizes that entry points for linkages and priority action need to adjust to the national context (6)

While some developing countries are marking an impressive success in configuring integrated packages of SRH/HIV/AIDS information and services and achieving reproductive health outcomes, many others are failing to follow such a modality of service delivery. This undesirable trend is likely to be responsible, even partially, for the failure of the dominant developing countries to get back to meet the health MDGs 4, 5 and 6 by 2015. Compellingly, global statistics are reflecting sad realties concerning these goals.

Worldwide, about 529, 000 women died during pregnancy and childbirth in 2000, mainly from preventable causes accompanied by more than 8 million women suffering life threatening complications of pregnancy leading to long-term morbidity (7). In 2006, a UNAIDS's update of the AIDS epidemic displayed a figure of 39.5 million people living with HIV/AIDS, with 4.3 million being newly infected, and about half were women (8).

These figures are staggering and are enough to justify a wakeup call for the national planners and policymakers as well as their global and regional partners to reinvigorate a well-functioning integrated system of SRH/HIV/AIDS information and services with a view to meeting the diverse client needs and maintain highest standards of equity and inclusiveness. Such systems are critical to the effectiveness, fairness and the cost of any comprehensive interlinked interventions (integrated care by stages in the life cycle). However, for this sort of system to operate and produce positive payoffs, countries need to improve the knowledge base for both effective advocacy and management for integrating HIV/AIDS to SRH programs. The importance of quality data and research for establishing the required knowledge base can not be stressed enough.

The Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages (9) provides a generic guide to addressing priority linkages in the health sector and highlights that actions will only be successful if build on the principles gender responsiveness, cultural sensitivity and human rights.

Data/Research Relevance to Integrated SRH/HIV/AIDS Services.

Information-based Advocacy for Integrated Services

The link between the need for an effective package of SRH/HIV/AIDS services at appropriate levels of the service delivery system in countries and the efforts to increase the impacts of the integrated programs is clear. High quality and relevant data are essential to successfully advocate and achieve the health goals of the SRH/HIV/AIDS interventions. Empirical evidence shape more informed decisions, increase awareness and foster constructive debate for strengthening positive synergies among the services.

To be effective, the health information used for advocacy has to be integrated in ways that facilitate analysis and linked to responses and actions related to the provision of various services at appropriate levels and functions of the health system. In this way it would be possible to associate HIV issues with broader concerns, such as inter-personal relationships, families and plans for future. HIV and sexual health are also strongly related with poverty and other health concerns and these links should be given more attention.

Combining Quantitative and Qualitative Data for Integrated Services.

As a way of making invisible forces determining both RH and HIV/AIDS information, services and counselling more visible, the quantitative indictors need to be supplemented with qualitative indicators to produce better understanding of the full picture of the reality, to support different advocacy objectives and to appropriately model the linkages between the concerned services. Purportedly, when quantitatively-drawn data and indictors are complemented and reinforced with prudently designed qualitative research findings, a wide range of sensitive SRH issues would possibly be studied and programmed (10).

As narrated by the latter source, there are numerous SRH subjects, such as sexual violence, GBV, post-traumatic stress syndrome among female adolescents victimized by violence, FGM, and lack of male involvement in RH matters, are recognized but much more the in-depth qualitative understanding is desired. Also, there are sensitive SRH issues, such as addiction, abortion, menopausal disorders, adolescent sexuality, etc. that are rough topics for quantitative research alone to clearly and comprehensibly investigate. Furthermore, the increasing emphasis on program evaluation necessitates the combined merits of both qualitative and quantitative methods, particularly when the program process parameters (what takes place during the intervention) and program outcome variables (success or failure in achieving the program goals) need to be distinguished and measured.

Cost Effectiveness Data

In a world in which resources are limited and problems are many (limited resources against unlimited ends), data and tools are needed to make rational decisions about how to prioritize integrated program needs and content. These data and derived tools can take on many forms, including economic or financial analysis, demographic and epidemiological analysis, and other ways to help planners and program managers make choices among the individual and societal needs to be met by integrated/packaged priority SRH/HIV/AIDS services at the various levels of health delivery systems (11).

Even though SRH issues are frequently considered to be human rights issues, there is a need to undertake more cost effectiveness studies in SRH to provide politicians with arguments with which to benchmark SRH interventions with other areas of health. Possibly the failure to do so has been partly responsible for low attention assigned to the broader SRH issues over the past years when compared to programmes prioritizing HIV/AIDS, TB and Malaria. Research and data needs to be reoriented towards highlighting positive synergies of holistic RH approach, as defined in Cairo Programme of Action.

Databases and indictors frameworks for Integrated Services

One of the greatest challenges to pursue an effective integrated package of HIV/AIDS and SRH services and information is the lack of timely, valid and reliable measures and indicators necessary for driving the linked programs. To develop such measures requires clarity on the key factors that contribute to or retard improvements in the health outcomes. Until recently, such indicators have been lacking since the operational frameworks that describe sexual and reproductive health outcomes have been poorly articulated.

The SRH care package as a whole does not lend itself to an easy measurement (quite apart from its individual components) nor does the concept of "universal access" which implies the use of effective services by everyone who needs them (12). The available knowledge and tools are not always adequate to tackle the significance and direction of linkages (positive or negative synergies) within and among the components of whole package.

Because the subject of SRH and HIV/AIDS is fraught with personal, interpersonal and contextual relations and the life-cycle events, any research work on any aspect of this subject should recognize that the conventional large survey data and their descriptive analysis will continue to produce inconclusive or indecisive results (13). According to this source, the relevance, reliability and validity of the sample survey-based or program-driven indictors are often questionable and are repeatedly contestable for providing an appropriate foundation for an integrated planning, programming and management of SRH.

Some of the commonly used indictors have a propensity to gauge RH related outcomes (total fertility rate, life expectancy at birth, maternal or neonatal mortality rate) whose connections to access of reproductive health services and information are not always clear. Some other indictors measure access to information (e.g. knowledge of HIV/AIDS or FGC related prevention practices), but not its effect on behavior. Still some indictors predict the actual use of reproductive health products, practices or services (contraceptive prevalence, births attended by skilled health personnel) without taking their effectiveness into account, while still others measure the existence of health or education facilities in aggregate (e.g. number of health centers or schools per 5,000 population) without reference to their distribution. Equally, several program-based indictors (e.g. contraceptive prevalence rate, condom use, immunization coverage, primary school enrolment ratio) manifest shortcomings in monitoring the SRH continuum care across life cycle or for scaling up efforts to achieve the health outcomes of integrated interventions.

Research Priorities in support of linking SRH/HIV and HIV/AIDS

Household surveys, ethnographic and other types of social science and epidemiological research can be designed at national and sub-national levels to assess the SRH health problems and needs for information and services of individuals, families and communities in various localities. The purpose is to provide evidence for designing more responsive and rights-based SRH/HIV/AIDS

policies, programs and packages of information and care. Research initiatives can be directed to the following topics, among others:

a) *Identifying the major bases of inequalities*.

Population and program based quantitative and qualitative research plays an essential role in identifying and overcoming social and economic inequalities and health- system deficiencies that obstruct progress to achieving fair integrated sexual and reproductive health for all. In-depth demographic, epidemiological and socio-cultural research can be explored to determine the nature and extent of prevailing inequalities in the distribution of sexual and reproductive health information, services and outcomes. Such research can also be used to identify patterns of inequality across and within the households, gender, age and communities with respect to the distribution of information and services with a view to narrowing the information, access and outcome gaps.

b) *Broadening Evidence for Exploiting Potential Synergies of Integrated Packages.*

In this regard, demographic, epidemiological, anthropological and socio-cultural research needs to be pursued for exploring the scope and nature of the causes and consequences of linking SRH and HIV/IDS services and information. For target population groups to reap the potential benefits of the integrated packages of services at various delivery points, decision-makers, managers and healthcare providers need to perceive such benefits and act strategically to support implementation of design and implement these packages. For this purpose research efforts should continue be advanced and sustained to:

- assess and track the nature and scope of often "invisible" and frequently "sensitive" sexual and reproductive health problems and risks among women, men and young people in particular population subgroups;
- analyze women's, men's and adolescents' perceptions of their sexual and reproductive health needs; of their knowledge, beliefs, attitudes and practices with respect to risks and prevention; of their capacity to protect their rights and health; and of their awareness of their responsibilities towards themselves and others;
- investigate the processes by which gender roles are acquired and reinforced in childhood and adolescence and their contribution to negative or passive attitudes of males toward SRH needs of related members:
- identify harmful practices such as FGM, all forms of sexual harassment, coercion and violence, child sexual abuse, and other violations of sexual and RH needs and rights; and
- compile evidence on the unmet needs among age-specific, sex-specific and socioeconomic status-specific groups of sexuality education and counselling, safe and acceptable methods of contraception, protection from and treatment of STIs/HIV, emergency obstetric care and other sexual and reproductive health needs.

c) *Research uncovering common barriers against integrated RH/HIV/AIDS Services.*

The fundamental principle of a person's right to attain the highest standard of sexual and reproductive health is frequently disillusioned by multiple and complex institutional and socio-

cultural barriers across and within the countries of today. Such barriers may manifest themselves in restricting the required packages for underserved subgroups of population, or may promote vertical approaches at the expense of integrated client-centred delivery systems, or may encourage disconnecting the continuum maternal, newborn and child health (MNCH) care, or may undermine the dual benefits of condom promotion initiatives.
Research initiatives should include areas with a view:

- to ascertaining the role of condom use in promoting safer sex and halting the spread of HIV/AIDS as well as its impacts on fertility and maternal and childhood mortality. This common goal of the integrated RH/HIV/AIDS services should always be addressed as a priority topic, particularly at times when anti-public health and family planning policies (both political and religious) against condom promotion initiatives threaten to undermine all the gains made in both intervention areas;
- to analysing the political determinants of the quantity and quality of sexual and reproductive health services, in order to strengthen the capacity of primary health care systems to provide comprehensive information and care;
- to identifying comprehensive, rights-based sexuality education curricula in schools, and to providing an evidence base for adaptation to local conditions;
- to assessing the nature and impact of national, state and local laws and policies relating to sexual and reproductive choices, gender equality, and protection from sexual harm, including coercion, violence and discrimination;
- to identifying training needs of sexual and reproductive health providers of various types and skill levels, and of the level of the health system in which various services should be provided, such as STIs/RTI/HIV counselling and screening;
- to identify and improve systems of communication, transportation and referrals among providers and facilities so that they form a coherent and accessible network of information and care at primary, secondary and tertiary levels and among specializations; and
- to reviewing providers' attitudes towards their work and towards their clients, including prejudicial attitudes or discriminatory practices with respect to clients (e.g., adolescents, ethnic minorities, homosexuals, commercial sex workers) or services (e.g., women needing post-abortion care) to identify training needs for improving provider-client relations.
- to understand the socio-cultural barriers and triggers to access and utilize services and information

Improved Evidence for Action

A recent literature review jointly undertaken by WHO,UNFPA,IPPF and UNAIDS and UCSF (14) provides recommendation for policy makers, programmers and researchers for modelling the provision of integrated RH/HIV/AIDS programs, and shows that progress is possible in fostering the process of packaging the various components of the programs.

For these linkages to properly function and to bring back desirable returns, a set of pre-requisites have to be actively present. Unquestionably, donor coordination, one-country health

plans, a health-systems focus, results-based financing, among other pertinent global initiatives, are laudable quests for and a welcome aspect of linking those activities and of reaping the benefits of the positive synergies arsing from the integrated approach to the SRH/HIV/AIDS services and information.

This paper reiterates that research evidence is vital to this approach since access to reliable knowledge and information is a key for effective advocacy for the integration and for designing and tracking the implementation of the integrated package of services and to ensure that the evidence leads to recognized benefit for clients.

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